

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

01520

1. DECEASED-NAME (Type or print) First Middle Last GEORGE WOODWARD BENNETT			2a. DATE OF DEATH Month Day Year 1 2 69			2b. HOUR 6:45 PM			
3. SEX M		4. RACE WHITE		5. DATE OF BIRTH JULY 12, 1892		6. AGE (In years last birthday) 76 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH TALBOT Md.			
10. CITY OR TOWN OF DEATH EASTON		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 335 N WASHINGTON		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY SALESMAN			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY TALBOT		13c. CITY OR TOWN EASTON		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 335 N WASHINGTON	
14. FATHER'S NAME First Middle Last JOSEPH BENNETT			15. MOTHER'S MAIDEN NAME First Middle Last MAY WOODWARD						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) YES			16b. SOCIAL SECURITY NO. (If give war or dates of service) M.W.#1-6411-217-AS-26484		17. INFORMANT MRS G.W. BENNETT		Address 335 N WASHINGTON EASTON, MD		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Prostate 185X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 11 years									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 69		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from May 1968, to January 2nd 1969, that (I) (we) last saw the deceased alive on January 1st 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE C.W. Bain M.D.				DEGREE M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED January 2nd 1969	
22d. PHYSICIAN'S NAME (Type) Callum R.W. Bain M.D.				22e. ADDRESS 210 E. Dover, Easton, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 1-4-69		23c. NAME OF CEMETERY OR CREMATORY WOODLAWN MEMORIAL Pk		23d. LOCATION (City or Town) (County) (State) Easton Talbot MD			
24. FUNERAL DIRECTOR MacLean				ADDRESS Easton, Md.		25a. REC'D BY REGISTRAR DATE JAN 6 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

X



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1

01528

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01521

1. DECEASED-NAME (Type or print) <i>Wesley Berry</i>			2a. DATE OF DEATH Month <i>Jan</i> Day <i>21</i> Year <i>1969</i>		2b. HOUR <i>6:30</i> M
3. SEX <i>Male</i>	4. RACE <i>Negro</i>	5. DATE OF BIRTH <i>Feb-15-1892</i>		6. AGE (In years last birthday) <i>76</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 1 YRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) <i>MD</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Talbot</i> Md.		
10. CITY OR TOWN OF DEATH <i>Easton</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Memorial</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MD</i>		13b. COUNTY <i>Talbot</i>	13c. CITY OR TOWN <i>Easton</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <i>Route 1 Box 275</i>
14. FATHER'S NAME First <i>MOSE</i> Middle <i>Berry</i> Last <i>Berry</i>		15. MOTHER'S MAIDEN NAME First <i>Rachel</i> Middle <i>Dobson</i> Last <i>Dobson</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>no</i> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <i>217-309338</i>	17. INFORMANT Address <i>James Berry</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral thrombosis</i> <i>4339</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (and) (did not) view the body after death.					
22b. SIGNATURE <i>E. C. H. Schmidt</i> MD		22c. DATE SIGNED <i>22 Jan 69</i>		22d. PHYSICIAN'S NAME (Type) <i>E. C. H. Schmidt</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>1/25/69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Chapel Corn</i>	
24. FUNERAL DIRECTOR <i>James S. Berthel Easton MD</i>		23d. LOCATION (City or Town) (County) (State) <i>Easton MD</i>		25a. BY REGISTRAR <i>JAN 30 1969</i>	
25b. REGISTRAR'S SIGNATURE <i>James S. Berthel</i>		25c. REGISTRAR'S SIGNATURE <i>James S. Berthel</i>			



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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
01529									
CERTIFICATE OF DEATH									
DoA									
1. DECEASED-NAME (Type or print) <u>Christine Bennett Brown</u>			2a. DATE OF DEATH Month <u>1</u> Day <u>9</u> Year <u>69</u>			2b. HOUR <u>11:15</u> M			
3. SEX <u>Female</u>		4. RACE <u>Negro</u>		5. DATE OF BIRTH <u>January 23, 1925</u>		6. AGE (In years lost birthday) <u>43</u> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <u>Florida</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>TALBOT</u>		Md.	
10. CITY OR TOWN OF DEATH <u>Easton</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Memorial Hospital</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Day Laborer</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Eskay Foods</u>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Maryland</u>		13b. COUNTY <u>Caroline</u>		13c. CITY OR TOWN <u>Federalsburg</u>		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER <u>Brooklyn Ave. Box 204</u>	
14. FATHER'S NAME First <u>John</u> Middle <u>Bennett</u> Last <u>Bennett</u>			15. MOTHER'S MAIDEN NAME First <u>Hester</u> Middle <u>Sharp</u> Last <u>Sharp</u>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <u>NO</u>		16b. SOCIAL SECURITY NO. <u>258-30-1053</u>		17. INFORMANT Address <u>Mrs. Rosalie Thomas, Federalsburg, Md. RFD</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> <u>2500</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. (b) <u>Diabetic coma</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Secondary anemia due to bleeding? ulcer</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>12 Hrs.</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>60</u> , to <u>Jan</u> , 19 <u>69</u> that (I) (we) last saw the deceased alive on <u>January 9</u> , 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>H. R. Trapnell</u>				DEGREE <u>M.D.</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>1-15-69</u>	
22d. PHYSICIAN'S NAME (Type) <u>H. R. Trapnell, M.D.</u>				22e. ADDRESS <u>Federalsburg, Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Jan. 14, 1969</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Federal Hill Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Federalsburg, Caroline, Md.</u>			
24. FUNERAL DIRECTOR <u>Frampton Funeral Home, Federalsburg, Md.</u>				ADDRESS <u>Frampton Funeral Home, Federalsburg, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>Jan. 20 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEMORANDUM FOR THE DIRECTOR

FROM: SAC, NEW YORK (100-20-1000)

SUBJECT: [Illegible]

RE: [Illegible]

DATE: [Illegible]

TO: [Illegible]

FROM: [Illegible]

SUBJECT: [Illegible]

RE: [Illegible]

DATE: [Illegible]

TO: [Illegible]

FROM: [Illegible]

SUBJECT: [Illegible]

RE: [Illegible]

DATE: [Illegible]

TO: [Illegible]

FROM: [Illegible]

SUBJECT: [Illegible]

RE: [Illegible]

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

01530

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01523

1. DECEASED-NAME (Type or Print) EMMA M Butler			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month 1 Day 6 Year 1969			2b. HOUR A M	
3. SEX Female	4. RACE Negro	5. DATE OF BIRTH 10/13/199	6. AGE (In years last birthday) 69 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD Month 1 Day 6 Year 1969	
7a. BIRTHPLACE (State or foreign country) MD		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH TALBOT	
10. CITY OR TOWN OF DEATH TROOP		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Route #2 Box 161		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) LABORER		12b. KIND OF BUSINESS OR INDUSTRY IND.	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD		13b. COUNTY Talbot		13c. CITY OR TOWN Troop		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER Route #2 Box 161		14. FATHER'S NAME EZKIEL		15. MOTHER'S MAIDEN NAME Brown		16. ADDRESS Brown Troop MD	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO. 138-06-4822		17. INFORMANT Robert		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL FAILURE		DUE TO, OR AS A CONSEQUENCE OF INFLUENZA		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 DAYS	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		(c)			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Louis S. Welty		EXAMINER'S NAME (Type) LOUIS S. WELTY		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ACTING DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county)		22b. DATE SIGNED 1-8-69	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1/9/69		23c. NAME OF CEMETERY OR CREMATORY Powders		23d. LOCATION (City or Town) (County) (State) Troop Talbot MD	
24. FUNERAL DIRECTOR George H. Doherty				25a. REC'D BY REGISTRAR Jan 9 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

11333

RECEIVED

FOR STATE
HIST. ARCH.

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11333

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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01531

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01524

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) George Edward Byrus			2a. DATE OF DEATH Month 1 Day 18 Year 69			2b. HOUR 3p M			
3. SEX MALE		4. RACE NEGRO		5. DATE OF BIRTH 5/10/1903		6. AGE (In years lost birthday) 65 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) U.S.A.		7b. CITIZEN OF WHAT COUNTRY U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH 1A/10t Md.			
10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Memorial Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) LABORER		12b. KIND OF BUSINESS OR INDUSTRY NONE			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) MARYLAND		13b. CITY OR TOWN CAROLINE RIDGELY		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER GENL. DELIVERY			
14. FATHER'S NAME First Middle Last JOHN BYRIS		15. MOTHER'S MAIDEN NAME First Middle Last ANNIE WINCHESTER							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) NO		16b. SOCIAL SECURITY NO. 213-01-7853		17. INFORMANT (FAMILY) Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure 4123 DUE TO, OR AS A CONSEQUENCE OF (b) A.S.H.D. DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 wks. YRS.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Cerebral Arteriosclerosis									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 1/10 , 19 69 to 1/18 , 19 69 , that (I) (we) last saw the deceased alive on 1/18 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE S. KRECH		DEGREE MD		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1/20/69			
22d. PHYSICIAN'S NAME (Type) S. KRECH JR.		22e. ADDRESS EASTON, ME.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 1/21/69		23c. NAME OF CEMETERY OR CREMATORY SPRINGGROVE, DENTON		23d. LOCATION (City or Town) (County) (State) CAROLINE MD			
24. FUNERAL DIRECTOR Chas. H. Denton, Md.		ADDRESS		25a. REC'D BY REGISTRAR JAN 24 1969		25b. REGISTRAR'S SIGNATURE O. C. Denton			

1881

RECORDS OF THE DEPARTMENT OF THE INTERIOR

UNITED STATES OF AMERICA

1881

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in parentheses in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN OF DEATH			<input checked="" type="checkbox"/> Month	Day	Year	2b. HOUR
Benjamin					Clark	ESTIMATED			<input type="checkbox"/> 1	8	1969	10 a.m.
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE	IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD			2d. HOUR	
Male	Negro	Unknown	68 YRS.	MONTHS	DAYS	HOURS	MIN.	Month	Day	Year	M	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			2d. HOUR			
Bellehaven, N.C.		USA				Talbot			M			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
Easton		Memorial				Laborer			None			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER			
Maryland			Talbot		Easton		YES <input type="checkbox"/> NO <input type="checkbox"/>		231 Port Street			
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last	
Benjamin			F.	Clark		Alverta				Hargrove		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS				
No			244 52 0644		Mary Griffin			1616 Delevan St. Norfolk Virginia				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												
PART 1. DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a) Coronary occlusion												
4109 DUE TO, OR AS A CONSEQUENCE OF												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												
(b) DUE TO, OR AS A CONSEQUENCE OF												
(c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?				
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
			HOUR A.M. 19 P.M.									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.				City or Town		County State		
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>												
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE		Louis S. Weity				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED				
EXAMINER'S NAME (Type)		Dr. Louis S. Weity				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		Jan. 9, 1969				
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
						ADDRESS (Street, city, town, or county)						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)		
Burial		1/12/69		Roosevelt Memorial		Norfolk		Chesapeake		Va.		
24. FUNERAL DIRECTOR		J B Dashiell Funeral Home				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Barbara L. Dashiell		426 Dover Easton, Md.				JAN 13 1969		Charles Judge				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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<div style="display: flex; justify-content: space-between;"> 01533 MARYLAND STATE DEPARTMENT OF HEALTH 01526 </div> <div style="text-align: center;"> DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH </div>													
1. DECEASED-NAME (Type or print) <i>Samuel</i>				First <i>Coffman</i>				2a. DATE OF DEATH Month <i>1</i> Day <i>12</i> Year <i>69</i>				2b. HOUR <i>1:30</i> M	
3. SEX <i>Male</i>		4. RACE <i>Negro</i>		5. DATE OF BIRTH <i>June 8th 1905</i>				6. AGE (In years last birthday) <i>63</i> YRS.		IF UNDER 1 YEAR MONTHS <i></i> DAYS <i></i>		IF UNDER 24 HRS. HOURS <i></i> MIN. <i></i>	
7a. BIRTHPLACE (State or foreign country) <i>Del.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Talbot</i>							
10. CITY OR TOWN OF DEATH <i>Easton</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Memorial</i>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Laborer</i>				12b. KIND OF BUSINESS OR INDUSTRY <i>Construction</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>md</i>		13b. COUNTY <i>Talbot</i>		13c. CITY OR TOWN <i>Easton</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>Route 1 Box 242 Easton</i>					
14. FATHER'S NAME First <i>Julius</i> Middle <i>Coffman</i> Last <i></i>				15. MOTHER'S MAIDEN NAME First <i>Jones</i> Middle <i></i> Last <i></i>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16b. SOCIAL SECURITY NO. <i>717-075428</i>		17. INFORMANT Address <i>Coffman</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Cardiovascular Accident</i> <i>4360</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Essential Hypertension</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>10 min.</i> <i>7 yrs.</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Viral Bursitis</i>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. <i></i> Month <i></i> Day <i>19</i> Year <i></i> P.M. <i></i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. <i></i> City or Town <i></i> County <i></i> State <i></i>									
22a. I certify that <i></i> (this hospital) attended the deceased from <i>1/11/69</i> , to <i>1/12/69</i> , that <i></i> (we) last saw the deceased alive on <i>1/12/69</i> , and that in (my) <i></i> opinion death occurred on the date and hour and from the causes stated above, (I) <i></i> (did) <i></i> (not) view the body after death.													
22b. SIGNATURE <i>Robert M. McDaniel</i> DEGREE <i></i> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED <i>1/12/69</i>							
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>1/16/69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Unionville</i>		23d. LOCATION (City or Town) (County) (State) <i>Unionville TA md</i>							
24. FUNERAL DIRECTOR <i>Charles R. Daniel Easton md</i>						25a. REC'D BY REGISTRAR DATE <i>JAN 21 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

1. The first part of the paper is devoted to a discussion of the general properties of the system. It is shown that the system is stable and that the solution is unique. The second part of the paper is devoted to a discussion of the numerical solution of the system. It is shown that the numerical solution is stable and that the error is of order $O(h^2)$. The third part of the paper is devoted to a discussion of the asymptotic behavior of the system. It is shown that the system converges to a steady state as $t \rightarrow \infty$.

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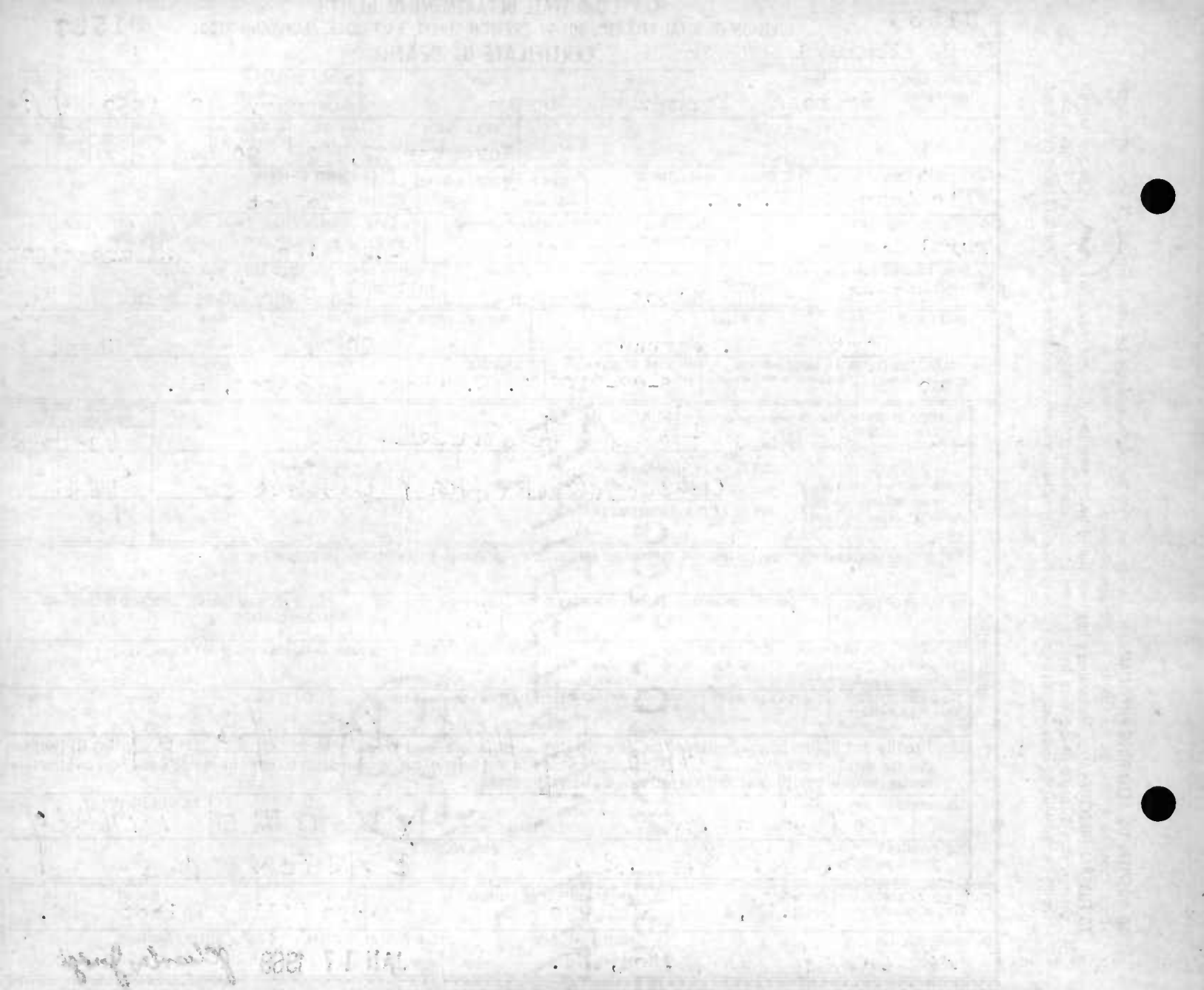
3. The first part of the paper is devoted to a discussion of the general properties of the system. It is shown that the system is stable and that the solution is unique. The second part of the paper is devoted to a discussion of the numerical solution of the system. It is shown that the numerical solution is stable and that the error is of order $O(h^2)$. The third part of the paper is devoted to a discussion of the asymptotic behavior of the system. It is shown that the system converges to a steady state as $t \rightarrow \infty$.

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1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

C1534				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				01527					
Item 13 Film 408 1/21/69 kk				CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) Frances Farrand Dodge				2a. DATE OF DEATH Month January Day 12 Year 1969				2b. HOUR 9 P. M.					
3. SEX F		4. RACE W		5. DATE OF BIRTH November 22, 1878				6. AGE (In years last birthday) 90 YRS.		7. UNDER 1 YEAR MONTHS DAYS 		8. UNDER 24 HRS. HOURS MIN. 	
7a. BIRTHPLACE (State or foreign country) Michigan		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Talbot Md.							
10. CITY OR TOWN OF DEATH rural Easton		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Deep Water Point				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife				12b. KIND OF BUSINESS OR INDUSTRY Housekeeper			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Talbot		13c. CITY OR TOWN Easton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Deep Water Point					
14. FATHER'S NAME First Hart Middle A. Farrand Last 				15. MOTHER'S MAIDEN NAME First Ann Middle Last Shank									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 325-07-2102		17. INFORMANT A. C. Dodge				Address Easton, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure 4123 DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO, OR AS A CONSEQUENCE OF (c) 										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1/2 Hour yrs.			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State 11/15/65 to 1/12/69									
22a. I certify that (I) (this hospital) attended the deceased from 11/15/65 to 1/12/69 , that (I) (we) last saw the deceased alive on 1/12/69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE S. KRECH, JR.				DEGREE 		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1/14/69					
22d. PHYSICIAN'S NAME (Type) S. KRECH, JR.				22e. ADDRESS EASTON, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE Jan. 16, 1969		23c. NAME OF CEMETERY OR CREMATORY Old Wye				23d. LOCATION (City or Town) (County) (State) Wye Mills Talbot Md.					
24. FUNERAL DIRECTOR 				ADDRESS Easton, Md.				25a. REC'D BY REGISTRAR DATE JAN 17 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			



01535

CERTIFICATE OF DEATH

01528

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) RAYMOND First DORRELL Middle DORRELL Last			2a. DATE OF DEATH Month 1 Day 20 Year 69			2b. HOUR 1:53 M	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH DEC. 7 - 1912		6. AGE (In years last birthday) 56 YRS.	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH TALBOT Md.	
10. CITY OR TOWN OF DEATH EASTON		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) WATERMAN		12b. KIND OF BUSINESS OR INDUSTRY XX	
13a. USUAL RESIDENCE (Where deceased lived admission) STATE MARYLAND		13b. COUNTY G.A. GRASONVILLE		13c. CITY OR TOWN YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER XX		14. FATHER'S NAME First GEORGE A. Middle DORRELL Last		15. MOTHER'S MAIDEN NAME First EMMA Middle WARNER Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b. SOCIAL SECURITY NO. 222-69-7984		17. INFORMANT MRS. R. DORRELL - GRASONVILLE MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia left 493X DUE TO, OR AS A CONSEQUENCE OF (b) Chronic asthma DUE TO, OR AS A CONSEQUENCE OF (c) last. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE [Signature]		22c. DATE SIGNED 20 Jan 69		22d. PHYSICIAN'S NAME (Type) E.C.H. Schmitt		22e. ADDRESS Capton, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE JAN. 23		23c. NAME OF CEMETERY OR CREMATORY WOODLAWN MEMORIAL		23d. LOCATION (City or Town) (County) (State) EASTON MARYLAND	
24. FUNERAL DIRECTOR Edgar L. Lane		24a. REC'D BY REGISTRAR DATE JAN 23 1969		24b. REGISTRAR'S SIGNATURE [Signature]			

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) ANNA WILMERING EGLSBDER			2a. DATE OF DEATH Month January Day 20 Year 1969			2b. HOUR 3A M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH December 12, 1892		6. AGE (In years lost birthday) 76 YRS.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Talbot County Md.	
10. CITY OR TOWN OF DEATH Boston		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Memorial		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY ---	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Talbot		13c. CITY OR TOWN St. Michaels		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER Harbor Road		14. FATHER'S NAME First Frank Middle Wilmering Last ---		15. MOTHER'S MAIDEN NAME First Minna Middle Kuhlmann Last ---		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No (If yes give war or dates of service) ---	
16b. SOCIAL SECURITY NO. 219-34-2791		17. INFORMANT Walter A. Eglseider, St. Michaels, Maryland		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CVA 4124 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) atherosclerotic C.V.D. DUE TO, OR AS A CONSEQUENCE OF (c) --- APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 36 hrs.		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State		22a. I certify that (I) (this hospital) attended the deceased from 1-18-69 , to 1-20-69 , that (I) (we) lost saw the deceased alive on 1-20-69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.	
22b. SIGNATURE Guy M. Reber, Jr., M.D.		22c. DATE SIGNED 1-20-69		22d. PHYSICIAN'S NAME (Type) GUY M. REBER, Jr., M.D.		22e. ADDRESS St. Michaels, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Jan 22, 1969		23c. NAME OF CEMETERY OR CREMATORY Olivet Cemetery		23d. LOCATION (City or Town) (County) (State) St. Michaels Talbot Md.	
24. FUNERAL DIRECTOR Harriet E. Leonard, St. Michaels, Md.		25a. BY REGISTRATION JAN 23 1969		25b. REGISTRAR'S SIGNATURE James J. Judge		25c. DATE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1-20-68

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4 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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01537

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01530

1. DECEASED-NAME (Type or print) ANNIE Elizabeth EVANS			2a. DATE OF DEATH Month 1 Day 4 Year 69			2b. HOUR 9:15 AM				
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 7/27/1893		6. AGE (In years lost birthday) 75 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Talbot Md.				
10. CITY OR TOWN OF DEATH EASTON			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Memorial Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD			13b. COUNTY TALBOT		13c. CITY OR TOWN EASTON		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 209 COURT ST.	
14. FATHER'S NAME First GEORGE T Middle RUSSELL Last EVANS			15. MOTHER'S MAIDEN NAME First WILHEMIA Middle TOWERS Last							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 217-28-3159		17. INFORMANT Address MRS. MAMIE GREGORY, EASTON, MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4122 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Pulmonary Disease DUE TO, OR AS A CONSEQUENCE OF (c) Myocardial Infarction PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Fractured Neck (left)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days 6 days 12-25-68	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 12:25 1968		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Fell down						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work of work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) Home		21f. LOCATION Street or R.F.D. No. City or Town County State 209 W. Court St. Easton Talbot Md.						
22a. I certify that (I) (this hospital) attended the deceased from 12-26 , 19 68 , to 1-4 , 19 69 , that (I) (we) last saw the deceased alive on 1-4 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE R. Lane Wroth, M.D.				DEGREE MD		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1-5-69		
22d. PHYSICIAN'S NAME (Type) R. Lane Wroth, M.D.				22e. ADDRESS St. Michaels, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 1/6/1969		23c. NAME OF CEMETERY OR CREMATORY OXFORD			23d. LOCATION (City or Town) (County) (State) OXFORD, MD			
24. FUNERAL DIRECTOR Maurice E. Newnam & Son Easton				ADDRESS Easton		25a. REC'D BY REGISTRAR DATE JAN 9 1969		25b. REGISTRAR'S SIGNATURE Maurice E. Newnam		

24

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR 1-15 (4)
30M REV. 1-68

01538		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				01531			
1. DECEASED-NAME (Type or print) <i>J. Harry Fairbank</i>						2a. DATE OF DEATH <i>1</i> Month <i>26</i> Day <i>1969</i> or		2b. HOUR <i>11:30</i>	
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>8/19/1912</i>		6. AGE (In years lost birthday) <i>56</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Talbot</i> Md.			
10. CITY OR TOWN OF DEATH <i>Tilghman</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Chicken Pt. Road</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Service Station Operator</i>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Talbot</i>		13c. CITY OR TOWN <i>Tilghman</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
14. FATHER'S NAME First Middle Last <i>J. Frank Fairbank</i>				15. MOTHER'S MAIDEN NAME First Middle Last <i>Annie White</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or (unknown) <i>no</i> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <i>213-01-8968</i>		17. INFORMANT <i>Mrs. J. Harry Fairbank, Tilghman, Md.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarct.</i> DUE TO, OR AS A CONSEQUENCE OF <i>atherosclerotic coronary a. d.</i> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>4109</i> (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>sudden</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>chronic cardiac failure.</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>1965</i> , 19 <i>1-26</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>2-10</i> 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>M. J. Beeser M.D.</i> DEGREE				22c. DATE SIGNED <i>1-22-69</i>		MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
22d. PHYSICIAN'S NAME (Type) <i>M. J. Beeser Jr.</i>				22e. ADDRESS <i>H. Michaels Md.</i>					
23a. BURIAL, CREMATION, REMOVAL, ETC.		23b. DATE <i>1/28/1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Methodist</i>		23d. LOCATION (City or Town) (County) (State) <i>Tilghman, Md.</i>			
24. FUNERAL DIRECTOR <i>MURICE E. NEWMAN & SON, Easton, Md.</i> ADDRESS				25a. REC'D BY REGISTRAR <i>J. Charles Judge</i> DATE <i>JAN 29 1969</i>		25b. REGISTRAR'S SIGNATURE			



Prepared by
the Department of
the Interior

Chronic and acute

5-10 1942 1-10-49

W. H. Hester
Superintendent
of
the
Department of
the Interior

1-10-49
JAN 24 1949

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01539

01532

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <i>Hester Priscilla Fields</i>			2a. DATE OF DEATH Month <i>Jan</i> Day <i>12</i> Year <i>1969</i>			2b. HOUR <i>10:00 P.M.</i>					
3. SEX <i>Female</i>		4. RACE <i>Negro</i>		5. DATE OF BIRTH <i>10-19-23</i>		6. AGE (In years lost birthday) <i>45</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>TALBOT</i>					
10. CITY OR TOWN OF DEATH <i>EASTON</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Memorial Hospital</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>DOMESTIC</i>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MARYLAND</i>			13b. COUNTY <i>TALBOT</i>			13c. CITY OR TOWN <i>ST. MICHAELS</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>TRUSTY ST.</i>	
14. FATHER'S NAME First <i>PRYERY</i> Middle <i>FIELDS</i> Last <i>FIELDS</i>			15. MOTHER'S MAIDEN NAME First <i>MILDRED</i> Middle <i>WELLS</i> Last <i>WELLS</i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>No</i>			16b. SOCIAL SECURITY NO. <i>219-01-6622</i>			17. INFORMANT Address <i>Mrs. Doris Ann Barnett, St. Michaels, Md.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>pneumonia</i> <i>471X</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Flex</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>24 hr</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) <i>cardiac failure, hypertension, Es Var, obesity</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <i>1953</i> , 19 <i>112</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>1-12</i> 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Henry M. Beeser</i>		DEGREE <i>MD</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>1-12-69</i>					
22d. PHYSICIAN'S NAME (Type) <i>Henry M. Beeser</i>		22e. ADDRESS <i>St. Michaels, Md.</i>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>Jan 15, 1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Thomas Memorial Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>St. Michaels, Md.</i>					
24. FUNERAL DIRECTOR <i>Ed Leonard</i>		ADDRESS <i>St. Michaels, Md.</i>		25a. REC'D BY REGISTRAR <i>JAN 17 1969</i>		25b. REGISTRAR'S SIGNATURE <i>James J. Jones</i>					

1333

10-10-1910

1333

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VR A15
30M REV. 1-58

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)		First <i>Pauline</i>	Middle <i>Elizabeth</i>	Lost <i>Fluharty</i>	2a. DATE OF DEATH Month <i>1</i> Day <i>12</i> Year <i>69</i>			2b. HOUR <i>10:20</i> M					
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>November 14, 1937</i>		6. AGE (In years lost birthday) <i>31</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.					
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Talbot</i> Md.							
10. CITY OR TOWN OF DEATH <i>Easton</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Memorial</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>housework</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Caroline</i>		13c. CITY OR TOWN <i>Federalsburg</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>Houston Branch Road</i>					
14. FATHER'S NAME First <i>William A.</i> Middle <i>Murphy</i> Lost		15. MOTHER'S MAIDEN NAME First <i>Mamie</i> Middle <i>Hessler</i> Lost		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i> (If yes give war or dates of service)						16b. SOCIAL SECURITY NO. <i>214-34-8252</i>		17. INFORMANT Address <i>William E. Fluharty, Federalsburg, Maryland</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Subarachnoid hemorrhage</i> <i>4309</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>20 hrs.</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from <i>11 pm</i> , 19 <i>69</i> , to <i>12 pm</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>12 pm</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>Thurston Harrison</i> M.D.		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>14 pm 69</i>							
22d. PHYSICIAN'S NAME (Type) <i>THURSTON HARRISON</i>		22e. ADDRESS <i>Easton, Maryland</i>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>Jan. 15, 1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Hill Crest Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Federalsburg, Maryland</i>							
24. FUNERAL DIRECTOR <i>Transpotion Funeral Home</i>		ADDRESS <i>Federalsburg Md.</i>		25a. REC'D BY REGISTRAR DATE <i>JAN 20 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>							

313

RECEIVED



Handwritten signature or initials.

Handwritten signature or initials.

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Handwritten signature or initials.

313

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15
30M REV. 1-68

MEDICAL CERTIFICATION

1. DECEASED NAME (Type or print) Elizabeth D. Foster		2a. DATE OF DEATH Month 1 Day 28 Year 69		2b. HOUR 8:30 AM
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH 10/7/1894		6. AGE (In years last birthday) 74 YRS.
7a. BIRTHPLACE (State or foreign country) MD	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH TALBOT Md.	
10. CITY OR TOWN OF DEATH EASTON	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Memorial Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWORK		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE MD	13b. COUNTY TALBOT	13c. CITY OR TOWN TRAPPE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER RFD
14. FATHER'S NAME First EDWARD O. Middle D. Last DYOTT	15. MOTHER'S MAIDEN NAME First MARGARET Middle PAIGE Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input type="checkbox"/> No, <input checked="" type="checkbox"/> (If yes give war or dates of service)	16b. SOCIAL SECURITY NO. 218-24-3881	17. INFORMANT Address PHILIP FOSTER, TRAPPE, MD		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure 4129 DUE TO, OR AS A CONSEQUENCE OF: (b) Recent Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF: (c) ASHD				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 wks 6 wks 9 mos
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Diabetes Mellitus - yrs				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. 50 City or Town 1/28 County 69 State		
22a. I certify that (I) (this hospital) attended the deceased 1/28 19 69 , to 1/28 19 69 , that (I) (we) lost the deceased 1/28 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE S. KEECH, JR.	DEGREE MD	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 3/3/69	
22d. PHYSICIAN'S NAME (Type) S. KEECH, JR.	22e. ADDRESS EASTON, MD			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 1/30/1969	23c. NAME OF CEMETERY OR CREMATORY SPRING HILL	23d. LOCATION (City or Town) EASTON, MD (County) (State)	
24. FUNERAL DIRECTOR Maurice E. Williamson	ADDRESS Easton, MD	25a. REC'D BY REGISTRAR FEB 5 1969	25b. REGISTRAR'S SIGNATURE Charles Judge	

01541

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01534

10710

THE UNIVERSITY OF CHICAGO PRESS

1954

CHICAGO, ILLINOIS

10710

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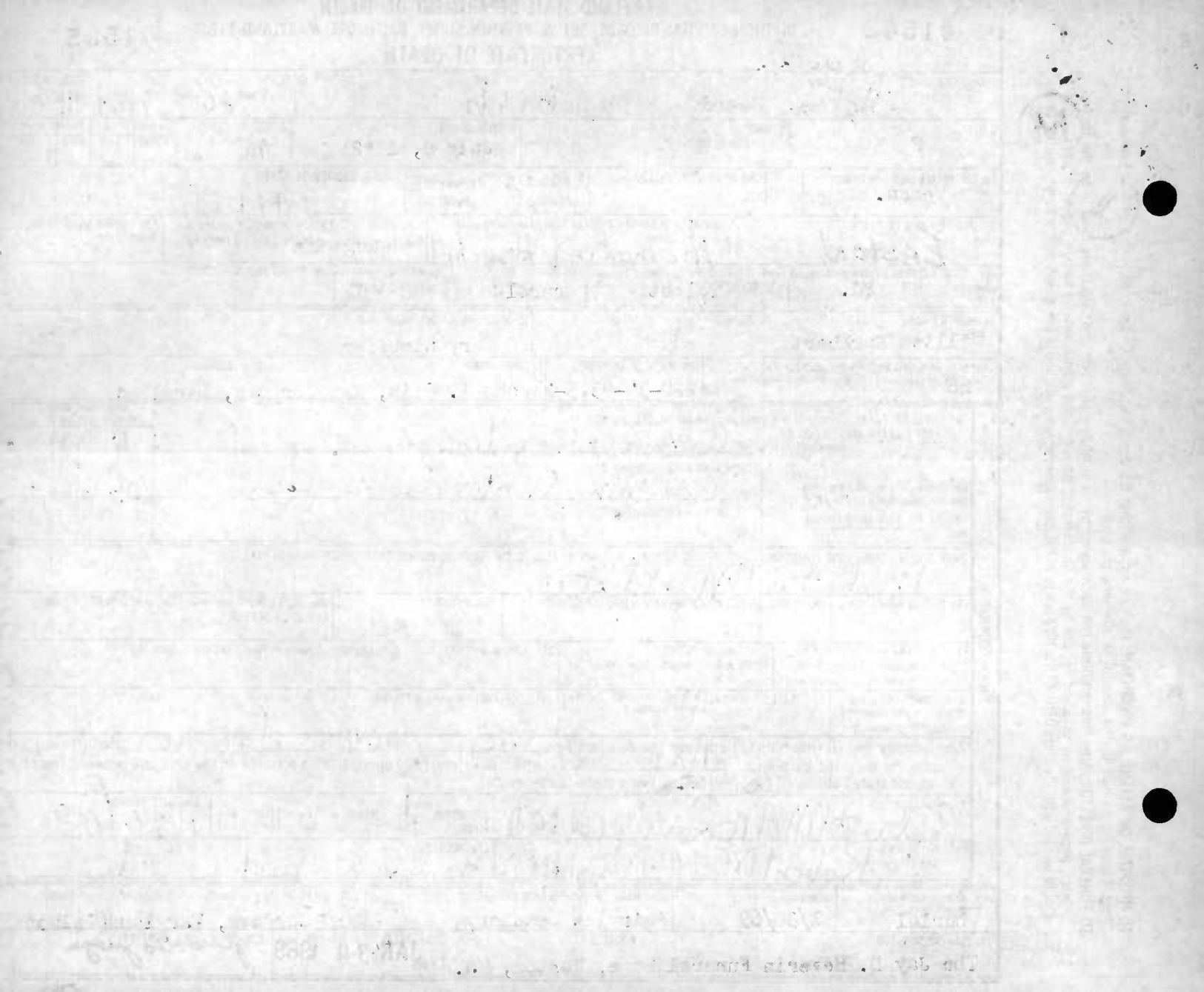
CHICAGO, ILLINOIS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 15
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
01542 <i>Maud</i> 01535									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) <i>Maud</i>			2a. DATE OF DEATH Month <i>26</i> Day <i>19</i> Year <i>1969</i>			2b. HOUR <i>11:45</i> M			
3. SEX <i>F</i>		4. RACE <i>W</i>		5. DATE OF BIRTH <i>July 9, 1892</i>		6. AGE (In years last birthday) <i>78</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>Penna.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Talbot</i> Md.			
1d. CITY OR TOWN OF DEATH <i>Easton</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Memorial Hosp. Talbot</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Assembly</i>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Talbot</i>		13c. CITY OR TOWN <i>rural</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
14. FATHER'S NAME First Middle Last <i>William Burkhart</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>Mary Stauffer</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No, or (unknown)		16b. SOCIAL SECURITY NO. <i>220-34-9375-1</i>		17. INFORMANT Address <i>John L. Geib, RFD Cordova, Maryland</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i> <i>4109</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Coronary Arteriosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>15 min</i> <i>2 mo</i>									
PART 2-OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Diabetes Mellitus</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>Sept 19 67</i> , to <i>11/26 1969</i> , that (I) (we) last saw the deceased alive on <i>11/23 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Robert M. McDonald, M.D.</i>				22c. DATE SIGNED <i>1/26/69</i>		22d. ADDRESS <i>Hanson St., Easton, Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>1/30/69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Fairview Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>RFD Cordova, Maryland (Talbot)</i>			
24. FUNERAL DIRECTOR <i>The Jay D. Heverin Funeral Home, Easton, Md.</i>				25a. REC'D BY REGISTRAR <i>JAN 30 1969</i>		25b. REGISTRAR'S SIGNATURE <i>John L. Geib</i>			



FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 6 Film 600 2/10/69 01543 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										01536					
1. DECEASED-NAME (Type or Print) Josephine			First Goines			Last			2a. DATE KNOWN OF DEATH ESTIMATED <input type="checkbox"/> 1 31 19 69		2b. HOUR M				
3. SEX Female		4. RACE Negroid		5. DATE OF BIRTH Unknown		6. AGE (In years) 76 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD Month 1 Day 31 Year 19 69		2d. HOUR M	
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Talbot				Md.		
10. CITY OR TOWN OF DEATH Easton			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) South Lane, Easton			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Hairdresser			12b. KIND OF BUSINESS OR INDUSTRY None						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Talbot			13c. CITY OR TOWN Easton			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER South Lane, Easton				
14. FATHER'S NAME Unknown			First Middle Last			15. MOTHER'S MAIDEN NAME Clara			First Middle Last Lawrence						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b. SOCIAL SECURITY NO. 213 22 66954			17. INFORMANT Clara Chase Rt.#4, Box 161, Easton, Md.			ADDRESS						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma - abdominal viscus 1950 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED above						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE Dr. Louis S. Welty			EXAMINER'S NAME (Type)			M.D. Actg			22b. DATE SIGNED 2-3-69						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 2/4/69			23c. NAME OF CEMETERY OR CREMATORY Royal Oak			23d. LOCATION (City or Town) (County) (State) Royal Oak Talbot Maryland						
24. FUNERAL DIRECTOR J B Dashiell Funeral Home Barbara L Dashiell						ADDRESS 426 Dover St Easton, Maryland			25a. REC'D BY REGISTRAR DATE FEB 4 1969		25b. REGISTRAR'S SIGNATURE Charles Judge				

01538

FOR SALE
#1111111

UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY

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WASHINGTON, D. C.

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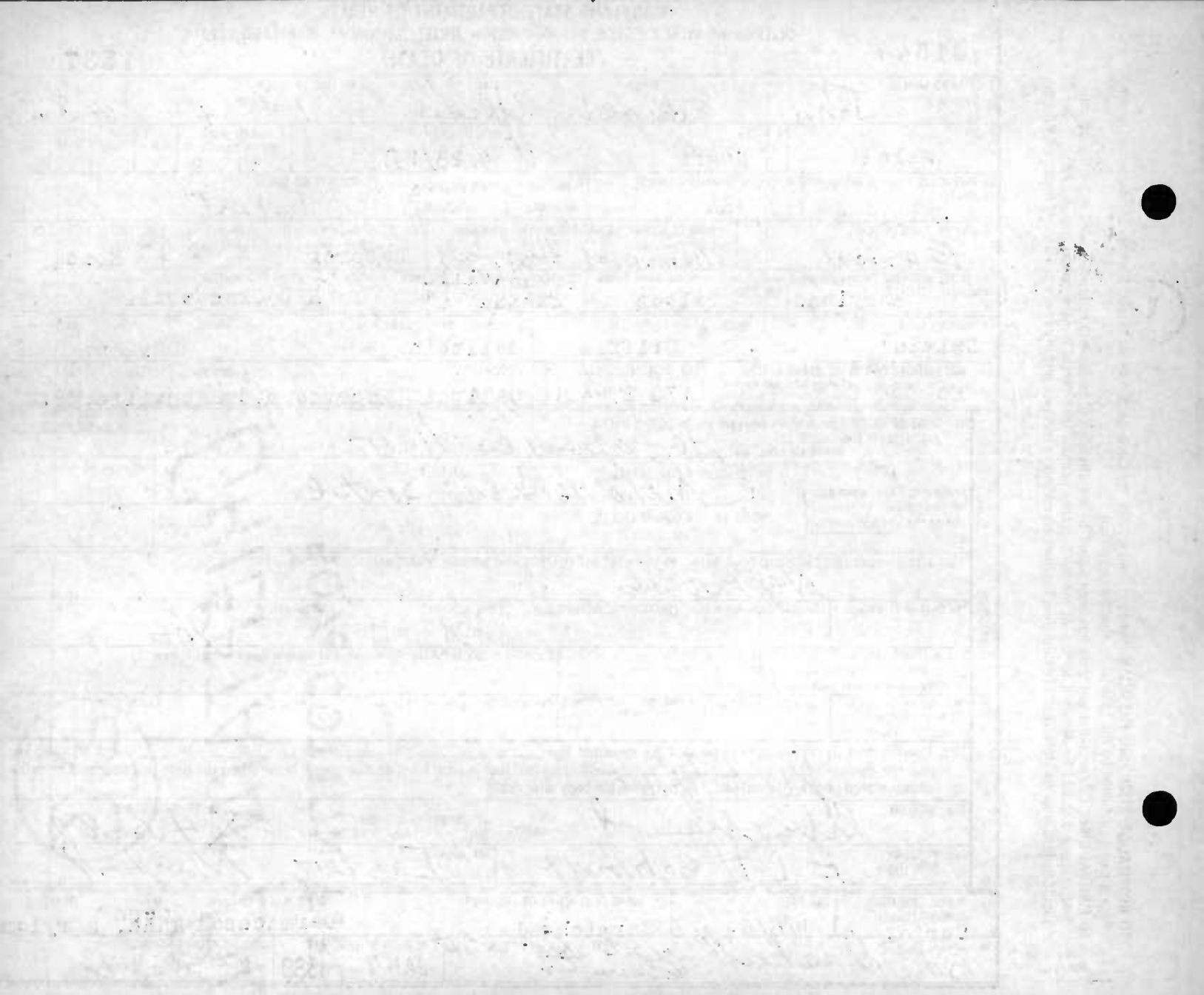
PLANT INDUSTRY
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (11)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
01544					01537				
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH			2b. HOUR	
John Edward Green					1 Month 4 Day Year 69			8 15 AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR	
Male		Negro		4/28/1915		53 YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		USA				Talbot Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Easton		Memorial Hospital		Laborer		None			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Talbot		Grasonville				RFD Grasonville	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
Calvin Griffin			Calithia Greene						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
No			170 27 4015		Calithia Robertson, Grasonville, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>441.9 Hemopericardium</u>									
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Medio necrosis cortex</u>									
DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
<u>Nephrosis</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE				DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED	
E.C.H. Schmidt								4-30-69	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
E.C.H. Schmidt				Easton, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		1/8/69		Carmicheal		Carmicheal Queen, Maryland			
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
B.L. Dashiell				JAN 7 1969		Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
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VR AIS (4)
ISM 7/61

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
01545											
01538											
1. PLACE OF DEATH a. COUNTY <u>Talbot</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>St. Michaels (rural)</u> c. LENGTH OF STAY IN <u>MARYLAND</u> <u>2 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Rio Vista Nursing Home</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Kent</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millington</u> d. STREET ADDRESS <u>----</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Charles S. Hague Sr.</u>						4. DATE OF DEATH Month <u>January</u> Day <u>31</u> Year <u>1969</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 14, 1909</u>		9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William T. Hague</u>						14. MOTHER'S MAIDEN NAME <u>Martha Sylvester</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>215-36-2160</u>		17. INFORMANT <u>Chas. S. Hague Jr.</u>		Address <u>Ruffsedale, Pa. RD 2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cokeheria</u> <u>188 X</u> DUE TO <u>carcinoma bladder</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>carcinoma bladder</u> (c) <u>carcinoma bladder</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>carcinoma bladder</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7-19-69</u> to <u>1-31-69</u> that (I) (v) last saw the deceased alive on <u>1-28-69</u> and that death occurred at <u>4:24 AM</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Victor Kennedy</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>Victor Kennedy</u>						22d. ADDRESS <u>St. Michaels Md</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>1-2-69</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Kennedyville Cemty</u>		23d. LOCATION (City, town or county) <u>Kennedyville</u>		23e. (State) <u>Kent</u>		23f. (M.D.) <u>Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Victor Kennedy</u>						ADDRESS <u>Still Pond, Maryland</u>		25a. REC'D BY REGISTRAR <u>FEB 5 1969</u>		25b. REGISTRAR'S SIGNATURE <u>William H. Hodge</u>	

31

Carminum Heller

Carminum Heller

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
01546									
CERTIFICATE OF DEATH									
01539									
1. DECEASED-NAME (Type or print) First Middle Last Percy A. Hardin					2a. DATE OF DEATH Month Day Year 1 3 1969			2b. HOUR 8:20 M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH 11/16/1880		6. AGE (In years last birthday) 88 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH TALBOT Md.			
10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Memorial			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) FARMING			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD		13b. COUNTY TALBOT		13c. CITY OR TOWN OXFORD		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER TRAPPE STATION	
14. FATHER'S NAME First Middle Last FRANK T. HARDIN					15. MOTHER'S MAIDEN NAME First Middle Last SUSAN MCNEIL				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No (unknown) (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO. 219-34-4024		17. INFORMANT Address MRS. GLADYS MORRIS, OXFORD, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute congestive heart failure</u> 4123 DUE TO, OR AS A CONSEQUENCE OF (b) <u>arteriosclerosis heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>many yrs</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 Day
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from February, 1968, to Jan., 1969, that (I) (we) last saw the deceased alive on Jan. 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Stephen P. Carney</u> DEGREE M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1-3-69		
22d. PHYSICIAN'S NAME (Type) Stephen P. Carney					22e. ADDRESS Easton, Maryland 21601				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 1/6/1969		23c. NAME OF CEMETERY OR CREMATORY OXFORD		23d. LOCATION (City or Town) (County) (State) OXFORD MD			
24. FUNERAL DIRECTOR Maurice E. Newnam					25a. REC'D BY REGISTRAR JAN 7 1969		25b. REGISTRAR'S SIGNATURE Charles Judge		

PLANT

INDUSTRY

1911

[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words like "Cotton", "Linen", and "Wool" are faintly visible.]

Report of the Secretary of the Department of Agriculture

[Faint, mostly illegible text at the bottom of the page, likely bleed-through from the reverse side.]

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH		2b. HOUR			
ALEXANDER SETH HARRISON JR.						Month Day Year		1969 35 M			
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD			
MALE	WHITE	1-29-50	17 YRS.	MONTHS	DAYS	HOURS	MIN.	Month Day Year	19 M		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		2d. HOUR			
MD		usa				TALBOT		M			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
EASTON			MEMORIAL			school					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
Md			Talbot		Wittman		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
ALEXANDER SETH HARRISON, SR.			MARY C. THOMPSON								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS				
NO			UNKN.		A. SETH HARRISON, SR.		WITTMAN, MD				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) G.S.W. CHEST											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?				
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
			2:20 PM 1-1-69		shotgun went off when picked up						
21d. INJURY OCCURRED		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		home		Wittman		Talbot		Md			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			22b. DATE SIGNED					
EXAMINER'S NAME (Type)			M.D. ASSISTANT MEDICAL EXAMINER			1-1-69					
Louis S. Welty			acting DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county)					
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
BURIAL		1/4/1969		SHERWOOD		SHERWOOD, MD					
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
MAURICE E. NEWNAM, SR., EASTON, MD						DATE JAN 3 1969		J Charles Judge			

11280

EXHIBIT - EXHIBIT OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers—Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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01548

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01541

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Sadie Virginia Harrison			2a. DATE OF DEATH Month January Day 30 Year 1969			2b. HOUR 11A M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH May 14, 1869		6. AGE (In years last birthday) 99 YRS.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Talbot Md.	
10. CITY OR TOWN OF DEATH St. Michaels		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Rio Vista Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Talbot		13c. CITY OR TOWN St. Michaels		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 109 West Chestnut		14. FATHER'S NAME First James Middle Rice Last Rice		15. MOTHER'S MAIDEN NAME First Sally Middle Stevens Last Stevens			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 216-56-0971-J		17. INFORMANT Harrison E. Leonard Address St. Michaels, Md. 21663			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) atherosclerotic cardiac 4124 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) cerebrovascular DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH -	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) advanced senile changes, cachexia							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 1-28-1969 to 1-30-1969 , that (I) (we) last saw the deceased alive on 1-28-1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Guy M Reeser M.D.				22c. DATE SIGNED 1-31-69		22d. ADDRESS St. Michaels, Md. 21663	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Feb. 1, 1969		23c. NAME OF CEMETERY OR CREMATORY Olivet Cemetery		23d. LOCATION (City or Town) (County) (State) St. Michaels, Talbot Md.	
24. FUNERAL DIRECTOR Harrison E. Leonard		ADDRESS St. Michaels, Md. 21663		25a. REC'D BY REGISTRAR Charles Joseph		25b. REGISTRAR'S SIGNATURE Charles Joseph	

1890

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
01549							01542		
1. DECEASED-NAME (Type or print) <i>Virginia</i>			First Middle Last <i>Hughes</i>			2a. DATE OF DEATH Month <i>1</i> Day <i>28</i> Year <i>69</i>			2b. HOUR <i>10:59</i> M <i>P</i>
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>7/11/1890</i>			6. AGE (In years lost birthday) <i>78</i> YRS.		IF UNDER 1 YEAR MONTHS OAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <i>MD</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>TALBOT</i> Md.			
10. CITY OR TOWN OF DEATH <i>EASTON</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>MEMORIAL</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MD</i>			13b. COUNTY <i>TALBOT</i>		13c. CITY OR TOWN <i>EASTON</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>206 GOLDSBORO ST.</i>
14. FATHER'S NAME First Middle Last <i>CHARLES H. HUGHES</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>MARY E.B. BURNETT</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <i>218-20-2654</i>		17. INFORMANT Address <i>HELENOR C. HUGHES, EASTON, MD.</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Coronary Thrombosis</i> <i>4109</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 hr.</i>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <i>28 Jan</i> , 19 <i>69</i> , to <i>28 Jan</i> , 19 <i>69</i> , that (I) (we) lost the deceased alive on <i>28 Jan</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Thurston Harrison MD</i> DEGREE					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>29 Jan 69</i>		
22d. PHYSICIAN'S NAME (Type) <i>THURSTON HARRISON</i>					22e. ADDRESS <i>Easton, Maryland</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>2/1/1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>SPRING HILL</i>		23d. LOCATION (City or Town) (County) (State) <i>EASTON, MD.</i>			
24. FUNERAL DIRECTOR <i>Maureen A. Neenan</i>		ADDRESS <i>501 Easton, MD</i>		25a. RECEIVED BY REGISTRAR <i>JAN 31 1969</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01550 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item 1 Film 408 1/13/69 kk

01543

1. DECEASED-NAME (Type or print) William Frank W. Hummer, Sr.			2a. DATE OF DEATH Month Day Year Jan. 4 1969			2b. HOUR 3:30 M.		
3. SEX Male		4. RACE White		5. DATE OF BIRTH 3/2/1894		6. AGE (In years last birthday) 74 YRS.		
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Talbot Md.		
10. CITY OR TOWN OF DEATH Easton			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Memorial			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Carpenter		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY Talbot		13c. CITY OR TOWN Trappe, Md.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER RFD 1			12b. KIND OF BUSINESS OR INDUSTRY					
14. FATHER'S NAME First Middle Last Henry Hummer			15. MOTHER'S MAIDEN NAME First Middle Last Rose Fairbanks					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no			16b. SOCIAL SECURITY NO. 218-07-8918		17. INFORMANT Mrs. W. Frank Hummer, Trappe, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Chronic Obstructive Pulmonary Emphysema								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 1/2, 1969, to 1/4, 1969, that (I) (we) last saw the deceased alive on 1/3, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE S. Krech, Jr.				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1/4/69		
22d. PHYSICIAN'S NAME (Type) S. Krech, Jr.				22e. ADDRESS Easton, Md.				
23a. BURIAL, CREMATION, or other final disposition		23b. DATE 1/7/1969		23c. NAME OF CEMETERY OR CREMATORY Upper Barbours		23d. LOCATION (City or Town) (County) (State) Trappe, Md.		
24. FUNERAL DIRECTOR Maurice E. Newnam + Son Easton				25a. REC'D BY REGISTRAR JAN 9 1969		25b. REGISTRAR'S SIGNATURE		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and may event, within 72 hours after death.

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30M REV. 1/68

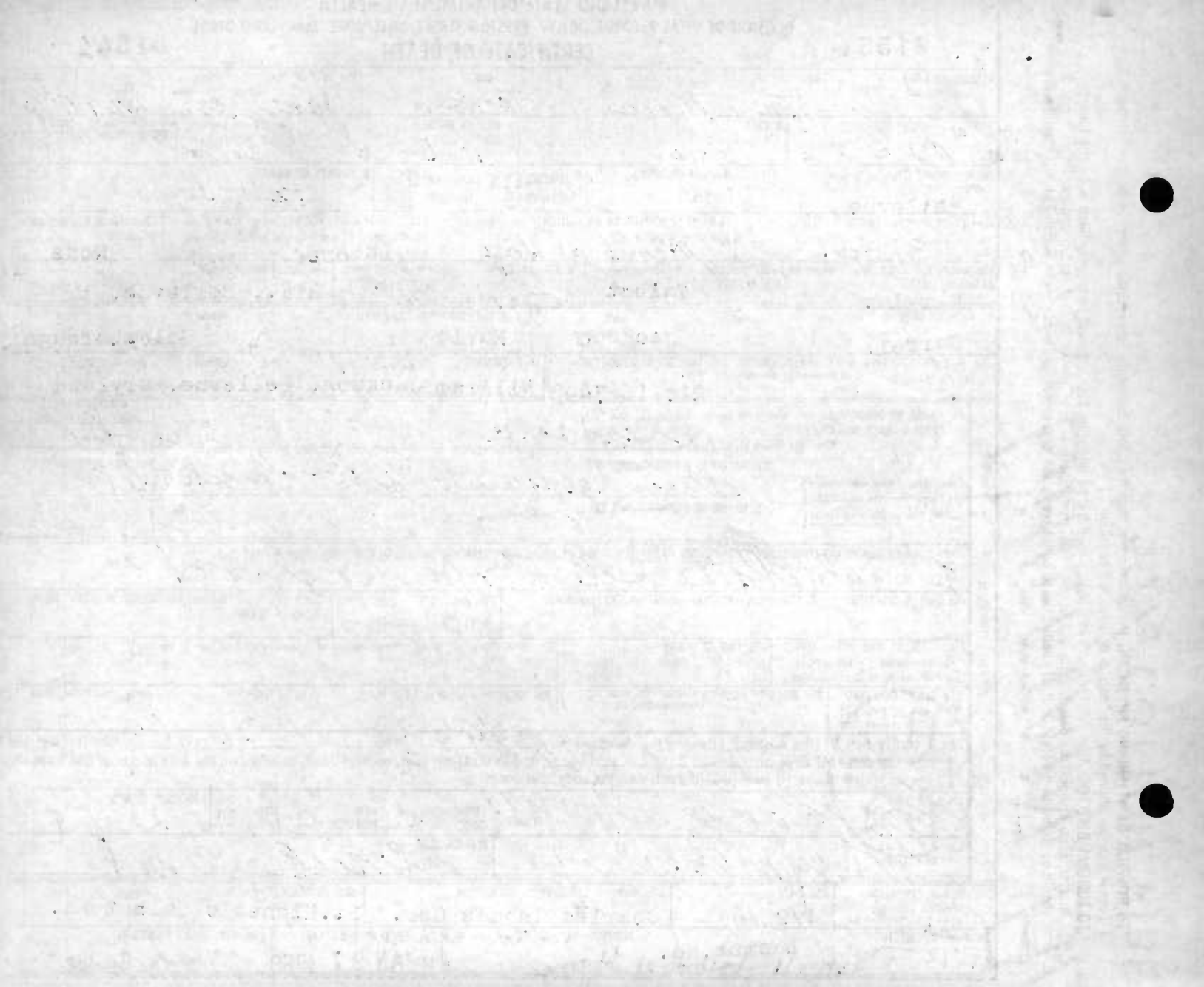
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01551

CERTIFICATE OF DEATH

01544

1. DECEASED-NAME (Type or print) <i>Quenton Morris Jackson</i>			2a. DATE OF DEATH Month <i>Jan</i> Day <i>20</i> Year <i>1969</i>			2b. HOUR <i>7:30</i> P.M.					
3. SEX <i>Male</i>		4. RACE <i>Negro</i>		5. DATE OF BIRTH <i>11-6-08</i>		6. AGE (In years last birthday) <i>60</i> YRS.		IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. DAYS HOURS MIN.			
7a. BIRTHPLACE (State or foreign country) <i>Bellevue</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Talbot</i>			Md.		
10. CITY OR TOWN OF DEATH <i>Easton</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Memorial Hosp.</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Laborer</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>None</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>			13b. COUNTY <i>Talbot</i>		13c. CITY OR TOWN <i>Bellevue</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>Rfd., Bellevue,</i>		
14. FATHER'S NAME First <i>Carroll</i> Middle <i>Jackson</i> Last <i>Mamie</i>			15. MOTHER'S MAIDEN NAME First <i>Goldsborough</i> Middle <i>Jackson</i> Last <i>Carroll</i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>No</i>			16b. SOCIAL SECURITY NO. <i>216 16 7498</i>			17. INFORMANT Address <i>William Jackson, Bellevue, Maryland</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>ischemia</i> <i>584X</i> DUE TO, OR AS A CONSEQUENCE OF <i>chronic glomerular nephritis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 wks</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Generalized atherosclerotic cardiovascular disease</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <i>1953</i> to <i>1-20</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>1-20</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Levy M. Breese, M.D.</i>				22c. DATE SIGNED <i>1-22-69</i>		22d. PHYSICIAN'S NAME (Type) <i>Levy M. Breese, M.D.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>1/25/69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Charles Thomas Cem.</i>		23d. LOCATION (City or Town) (County) (State) <i>St. Michaels Talbot Md.</i>					
24. FUNERAL DIRECTOR <i>J.B. Dashiell Funeral Home</i>				Address <i>Easton, Md. 426 Dover St.</i>		25a. REC'D BY REGISTRAR DATE <i>JAN 27 1969</i>		25b. REGISTRAR'S SIGNATURE <i>R. Michael, Judge</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR AN (4)
30M REV. 1-68

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print) First Middle Last <i>Morothy Nellie Jester</i>					2a. DATE OF DEATH Month Day Year <i>Jan 13 1969</i>			2b. HOUR <i>9:35</i> M		
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>9-15-24</i>		6. AGE (In years last birthday) <i>44</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>TALBOT</i> Md.				
10. CITY OR TOWN OF DEATH <i>Easton</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Memorial Hosp.</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>			13b. COUNTY <i>Queen Annes</i>		13c. CITY OR TOWN <i>Queenstown</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>None</i>	
14. FATHER'S NAME First Middle Last <i>John ? Thomas</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>Lillie May Ruark</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown? <i>No</i> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <i>- - -</i>		17. INFORMANT Address <i>LeCompte Funeral Service records</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Septic coma</i> <i>571.0</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>nutritional anorexia</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Chronic alcoholism</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> <i>5 yrs</i> <i>26 yrs</i>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>9-15</i> , 19 <i>65</i> , to <i>1-13</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>1-13</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Stephen P. Carney</i>					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>1-15-69</i>			
22d. PHYSICIAN'S NAME (Type) <i>Stephen P. Carney</i>					M.D.		22e. ADDRESS <i>Easton, Maryland 21601</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>Jan 16 1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Dorchester Memorial Park</i>		23d. LOCATION (City or Town) (County) (State) <i>Cambridge, Maryland</i>				
24. FUNERAL DIRECTOR <i>ANTHONY R. LeCompte</i>					ADDRESS <i>308 High St</i>		25a. BY REGISTRAR <i>JAN 17 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

UNITED STATES DEPARTMENT OF THE INTERIOR
BUREAU OF LAND MANAGEMENT

WATER RESOURCES DIVISION
SALT LAKE CITY, UTAH

DATE: 10/1/77

10/1/77

10/1/77

10/1/77

10/1/77

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR 11-1-68
30M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01553

CERTIFICATE OF DEATH

01546

45
12 PM

1. DECEASED-NAME (Type or print) First Middle Last John H Johnson			2a. DATE OF DEATH Month Day Year 1 24 69		2b. HOUR 45 PM
3. SEX MALE	4. RACE Colored	5. DATE OF BIRTH 8/25/1870		6. AGE (In years lost birthday) 98 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A	8. MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Talbot Md.		
1d. CITY OR TOWN OF DEATH Easton	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Memorial Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Labor	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	13b. COUNTY Queen Anne's	13c. CITY OR TOWN Church Hill	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER R.F.D.	
14. FATHER'S NAME First Middle Last John Johnson		15. MOTHER'S MAIDEN NAME First Middle Last Katie G. bbs			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. UNK.	17. INFORMANT Address MRS. MARGARET WELLS CENTREVILLE Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the stomach 15/9 DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Unknown
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 1-15, 1969, to 1-24, 1969, that (I) (we) last saw the deceased alive on 1-24, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Robert W. Trever M.D.		22c. DATE SIGNED 1-25-69		22d. PHYSICIAN'S NAME (Type) Robert W Trever M. D.	
22e. ADDRESS Route 50 Easton, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1/28/1969	23c. NAME OF CEMETERY OR CREMATORY SALEM CEMETERY		23d. LOCATION (City or Town) (County) (State) R.F.D. Church Hill, Md.
24. FUNERAL DIRECTOR Bennett W. Wally		ADDRESS Chesler Town, Md		25a. REC'D BY REGISTRAR DATE JAN 30 1969	
				25b. REGISTRAR'S SIGNATURE	

1. The purpose of this study is to determine the effect of the treatment on the response of the subjects. The results of the study are presented in the following table.

Treatment	Response
Control	1.0
1.0 mg	1.5
2.0 mg	2.0
4.0 mg	3.0
8.0 mg	4.0
16.0 mg	5.0
32.0 mg	6.0
64.0 mg	7.0
128.0 mg	8.0
256.0 mg	9.0
512.0 mg	10.0

2. The results of the study show that the treatment has a significant effect on the response of the subjects. The response increases with the dose of the treatment.

3. The results of the study also show that the treatment has a significant effect on the response of the subjects. The response increases with the dose of the treatment.

4. The results of the study also show that the treatment has a significant effect on the response of the subjects. The response increases with the dose of the treatment.

5. The results of the study also show that the treatment has a significant effect on the response of the subjects. The response increases with the dose of the treatment.

6. The results of the study also show that the treatment has a significant effect on the response of the subjects. The response increases with the dose of the treatment.

7. The results of the study also show that the treatment has a significant effect on the response of the subjects. The response increases with the dose of the treatment.

8. The results of the study also show that the treatment has a significant effect on the response of the subjects. The response increases with the dose of the treatment.

9. The results of the study also show that the treatment has a significant effect on the response of the subjects. The response increases with the dose of the treatment.

10. The results of the study also show that the treatment has a significant effect on the response of the subjects. The response increases with the dose of the treatment.

01554

CERTIFICATE OF DEATH

01547

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1. DECEASED-NAME (Type or print) <u>E. Elmer Tilghman</u>			2a. DATE OF DEATH Month <u>1</u> Day <u>29</u> Year <u>69</u>			2b. HOUR <u>9:45</u> A.M.				
3. SEX <u>Male</u>		4. RACE <u>White</u>		5. DATE OF BIRTH <u>August 28, 1895</u>		6. AGE (In years last birthday) <u>73</u> YRS.		IF UNDER 1 YEAR MONTHS <u>7</u> DAYS <u>15</u>		
7a. BIRTHPLACE (State or foreign country) <u>Caroline Co.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Talbot</u> Md.				
10. CITY OR TOWN OF DEATH <u>Easton</u>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Memorial</u>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Farmer</u>			12b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Maryland</u>			13b. COUNTY <u>Caroline</u>		13c. CITY OR TOWN <u>Preston</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <u>R.F.D.</u>	
14. FATHER'S NAME First <u>Glencoe</u> Middle <u>K.</u> Last <u>Kelley</u>			15. MOTHER'S MAIDEN NAME First <u>Leona</u> Middle <u></u> Last <u>Patchett</u>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes XXXXX</u>			16b. SOCIAL SECURITY NO. <u>W W 1 217-36-0480</u>			17. INFORMANT Address <u>Mrs. Mildred M. Kelley, Preston, Md. R.F.D.</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Vascular Collapse cause unknown</u> <u>4123</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>many years</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Right colon resection for Carcinoma. 1/23/69</u>										
19a. DATE OF OPERATION <u>1/23/69</u>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Carcinoma of Cecum</u>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. <u></u> Month <u></u> Day <u></u> Year <u>19</u> P.M. <u></u>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. <u></u> City or Town <u></u> County <u></u> State <u></u>				
22a. I certify that (I) (this hospital) attended the deceased from <u>1/17</u> , 19 <u>69</u> , to <u>1/29</u> , 19 <u>69</u> , that (I) (we) lost saw the deceased alive on <u>1/29</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>J.T.B. Ambler, M.D.</u>						22c. DATE SIGNED <u>2/1/69</u>		22d. PHYSICIAN'S NAME (Type) <u>J.T.B. Ambler, M.D.</u>		
22e. ADDRESS <u>Easton, Md. 21601</u>										
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE <u>Feb. 1, 1969</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Junior Order Cemetery</u>			23d. LOCATION (City or Town) (County) (State) <u>Preston Caroline Md.</u>		
24. FUNERAL DIRECTOR ADDRESS <u>Tramptons Funeral Home Frederick Md.</u>						25a. RECD BY REGISTRAR DATE <u>FEB 7 1969</u>		25b. REGISTRAR'S SIGNATURE <u></u>		

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1

01555

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01548

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <i>Robert E. Lednum</i>			2a. DATE OF DEATH Month <i>1</i> Day <i>21</i> Year <i>69</i>			2b. HOUR <i>1:15</i> PM			
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>10/3/1874</i>		6. AGE (In years last birthday) <i>94</i> YRS.		IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>MD</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Talbot</i> Md.			
10. CITY OR TOWN OF DEATH <i>Easton</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Memorial</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>WATERMAN</i>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MD</i>		13b. COUNTY <i>TALBOT</i>		13c. CITY OR TOWN <i>TILGHMAN</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
14. FATHER'S NAME First <i>CHARLES T.</i> Middle <i>LEDNUM</i>			15. MOTHER'S MAIDEN NAME First <i>SARAH E.</i> Middle <i>CUMMINGS</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes (no, or unknown) <i>No</i> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <i>219-34-3724</i>		17. INFORMANT Address <i>WILLIAM E. LEDNUM, SR. TILGHMAN, MD</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CVA</i> <i>4379</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>atherosclerotic cerebro</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>vase.</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs</i>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>1952</i> , 19____, to <i>1-21</i> , 19 <i>69</i> , that (I) (we) lost the deceased alive on <i>1-21</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.									
22b. SIGNATURE <i>Wm. M. Breese, MD</i> DEGREE ATTENDING <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED <i>1-22-69</i>					
22d. PHYSICIAN'S NAME (Type) <i>Wm. M. Breese, Jr.</i>				22e. ADDRESS <i>St. Michael's</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE <i>1/24/1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>METHODIST</i>		23d. LOCATION (City or Town) (County) (State) <i>TILGHMAN, MD</i>			
24. FUNERAL DIRECTOR ADDRESS <i>Maurice E. Keenano, Jr. Easton, Md</i>				25a. REC'D BY REGISTRAR DATE <i>JAN 24 1969</i>		25b. REGISTRAR'S SIGNATURE <i>John A. Judge</i>			

01258

UNITED STATES DEPARTMENT OF AGRICULTURE

UNITED STATES DEPARTMENT OF AGRICULTURE

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CERTIFICATE OF DEATH

01549

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY QUEEN ANNES'S			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TRAPPE			c. LENGTH OF STAY IN 1b 14R. 9 mos.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CENTREVILLE		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Box 76, GREENFIELD AVE.				d. STREET ADDRESS 213 BELVEDERE AVE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First PEARL Middle EURELIA Last LEWIS				4. DATE OF DEATH Month Jan Day 3 Year 19 69			
5. SEX FEMALE		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH APRIL 13, 1883	
9. AGE (In years lost birthday) yrs. 85		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED CLERK		11. BIRTHPLACE (County & State, or foreign country) QUEEN ANNES'S CO, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN SAMUEL LEWIS				14. MOTHER'S MAIDEN NAME EURELIA McClyment			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 408-34-2446		17. INFORMANT NIECE Address Mrs. Thomas D. Dodd, CENTREVILLE, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thrombosis, left middle cerebral art. DUE TO 4339 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ DUE TO _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH 2 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1. 2 , 19 69 , to 1. 3 , 19 69 , that (I) (we) last saw the deceased alive on 1. 2 , 19 69 , and that death occurred at 3 P.M. from causes and on the (date stated above).							
22a. SIGNATURE S. K. RECH, JR.				22b. DATE SIGNED 1. 3. 69		22c. PHYSICIAN'S NAME (Type) S. K. RECH, JR.	
22d. ADDRESS EASTON, Md.							
23a. BURIAL-CREATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF JANUARY 6, 1968		23c. NAME OF CEMETERY OR CREMATORY CHESTERFIELD CEMETERY, CENTREVILLE, Q.A. Co, Md.		23d. LOCATION (City or town) (County) (State)	
24. FUNERAL DIRECTOR Donald B. Burt, Jr., Burt Bros, Centerville, Md.				25a. REC'D BY REGISTRAR DATE JAN 8 1969		25b. REGISTRAR'S SIGNATURE Charles J. Jones	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
George			Lyons			Jan 18 1969			3:40 AM
3. SEX	4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
MALE	WHITE		JUNE 26, 1902			66 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
MARYLAND		USA				TALBOT Md.			
1d. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Easton			Memorial			FARM LABORER			xx
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND			G.A.		PRICE			xx	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
UNKNOWN			UNKNOWN						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
					WM. McFARLAND - PRICE, MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> 4109 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Uncertain</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1-14-69
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to <u>1-18</u> , 19 <u>69</u> , that (I) (we) lost saw the deceased alive on <u>1-17</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Robert W. Trever M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1-18-69		
22d. PHYSICIAN'S NAME (Type) Robert W Trever M. D.					22e. ADDRESS Easton, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)	
BURIAL		JAN. 20		CHURCH HILL		CHURCH HILL		MD.	
24. FUNERAL DIRECTOR Edgar H. Lane Church Hill, Md.					25a. RECORD BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE JAN 22 1969		

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DEPARTMENT OF HEALTH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED NAME (Type or print) First Middle Last <i>Joseph H. Nichols</i>						2a. DATE OF DEATH Month Day Year <i>Jan 15 1969</i>			2b. HOUR MIN. <i>8:12</i>			
3. SEX <i>MALE</i>		4. RACE <i>NEGROID</i>		5. DATE OF BIRTH <i>5-17-1899</i>			6. AGE (In years lost birthday) <i>69</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <i>Talbot</i>					
10. CITY OR TOWN OF DEATH <i>Easton</i>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Memorial</i>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) State <i>Maryland</i>				13b. COUNTY <i>Talbot</i>		13c. CITY OR TOWN <i>Easton</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>310 Talbot Street</i>		
14. FATHER'S NAME First Middle Last <i>Joseph H. Nichols</i>				15. MOTHER'S MAIDEN NAME First Middle Last <i>Cecelia E. Grayson</i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) <i>No</i>				16b. SOCIAL SECURITY NO. <i>218 16 7539</i>		17. INFORMANT Address <i>Saint Michaels, Maryland</i> <i>Leroy Nichols 310 Talbot St.</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Multiple myeloma</i> <i>203x</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.												
22b. SIGNATURE <i>E. C. H. Schmidt M.D.</i>				22c. DATE SIGNED <i>1/17/69</i>				22d. PHYSICIAN'S NAME (Type) <i>E. C. H. Schmidt</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>1/20/69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Chas. Thomas Cemetery St. Michaels-Tal.-Md.</i>				23d. LOCATION (City or Town) (County) (State) <i>Easton, Md.</i>				
24. FUNERAL DIRECTOR <i>B. Dashiell</i>				25a. REC'D BY REGISTRAR <i>426 Dover St.</i>				25b. REGISTRAR'S SIGNATURE <i>J. E. Dashiell</i>				

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 23 Film 4109
2/7/69 klc 01553

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01552

1. DECEASED-NAME (Type or Print) AVERY Ernest ORNETT			2a. DATE KNOWN <input checked="" type="checkbox"/> OF ESTI- DEATH MATED <input type="checkbox"/> Jan 29 1969			2b. HOUR 9:18		
3. SEX male	4. RACE white	5. DATE OF BIRTH 7-8-94	6. AGE (In years last birthday) 74 YRS.	IF UNDER 1 YEAR MONTHS DAYS 	IF UNDER 24 HRS. HOURS MIN. 	2c. DATE PRONOUNCED DEAD Month Day Year 19		
7a. BIRTHPLACE (State or foreign country) md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Talbot		
10. CITY OR TOWN OF DEATH Easton			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Memorial			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Business & Merchant		12b. KIND OF BUSINESS OR INDUSTRY Retail
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE md.			13b. COUNTY Talbot		13c. CITY OR TOWN Trappe	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 117 S. Main Street	
14. FATHER'S NAME First John Middle ORNETT Last 			15. MOTHER'S MAIDEN NAME First Hilda Middle DAVIS Last 			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		
16b. SOCIAL SECURITY NO. 214-32-6476			17. INFORMANT Mildred G. Ornett			ADDRESS Trappe, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) 								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. 19 P.M. 		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE Louis Welch		EXAMINER'S NAME (Type) WELT		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED 1-30-69		
ADDRESS (Street, city, town, or county)								
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE Feb. 1, 1969		23c. NAME OF CEMETERY OR CREMATORY Spring Hill		23d. LOCATION (City or Town) (County) (State) Easton, Talbot Co., Md.		
24. FUNERAL DIRECTOR Jay D. Houshain, Easton, Md.				ADDRESS		25a. REC'D BY REGISTRAR DATE FEB 3 1969		25b. REGISTRAR'S SIGNATURE Judge

1153

RECEIVED BY THE
MEDICAL DEPARTMENT OF THE ARMY
WASHINGTON, D. C.

ALL INFORMATION CONTAINED
HEREIN IS UNCLASSIFIED



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01560

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01553

1. DECEASED-NAME (Type or print) <i>Gordon Scott Pugh</i>			2a. DATE OF DEATH Month <i>1</i> Day <i>13</i> Year <i>69</i>			2b. HOUR <i>7³⁰ A</i>			
3. SEX <i>MALE</i>		4. RACE <i>WHITE</i>		5. DATE OF BIRTH <i>6/11/1907</i>		6. AGE (In years last birthday) <i>61</i> YRS.		IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>ILL.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>TALBOT</i> Md.			
10. CITY OR TOWN OF DEATH <i>EASTON</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Memorial Hospital</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MD</i>		13b. COUNTY <i>TALBOT</i>		13c. CITY OR TOWN <i>EASTON</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>R.D. 1</i>	
14. FATHER'S NAME First <i>ERMAN A.</i> Middle <i>PUGH</i> Last <i>PUGH</i>			15. MOTHER'S MAIDEN NAME First <i>EDITH</i> Middle <i>SINCLAIR</i> Last <i>SINCLAIR</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> or unknown <input type="checkbox"/> (If yes give war or dates of service) <i>YES</i> <i>WW II</i>		16b. SOCIAL SECURITY NO. <i>215-38-0998</i>		17. INFORMANT Address <i>MRS. GORDON S. PUGH, EASTON, MD</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Gangrene, right foot</i> <i>2509</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Diabetes mellitus</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Chronic pancreatitis</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Nov. 1968</i> <i>20 years</i> <i>20 years</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>12-26</i> , 19 <i>61</i> , to <i>1-13</i> , 19 <i>69</i> , that (I) (we) lost saw the deceased alive on <i>1-12</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Robert W. Trever</i>					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>1/16/1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>CHRIST CHURCH YARD</i>		23d. LOCATION (City or Town) (County) (State) <i>CAMBRIDGE, MD.</i>			
24. FUNERAL DIRECTOR <i>Maurice K. Neumann</i>					25a. REC'D BY REGISTRAR DATE <i>JAN 20 1969</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

01523

REPORT OF DEATH

1954

Name of deceased		Date of death	
Sex		Age	
Place of birth		Date of birth	
Cause of death		Place of death	
Occupation		Education	
Marital status		Religion	
Social Security Number		Maiden name	
Signature of declarant		Signature of physician	
Date of declaration		Date of death	

1

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1, 2, and 3, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

01561

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

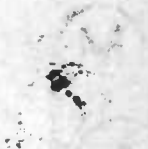
CERTIFICATE OF DEATH

01554

1. DECEASED-NAME (Type or print) James Fletcher Ruggold			2a. DATE OF DEATH JAN 24 1969			2b. HOUR 4:45 M			
3. SEX M		4. RACE N		5. DATE OF BIRTH AUG 24, 1904		6. AGE (In years last birthday) 64 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Talbot Md.			
10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Memorial		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Farmer			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE MD		13b. COUNTY CAROLINE		13c. CITY OR TOWN CELELY		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
14. FATHER'S NAME First HENRY Middle RINGGOLD Last RINGGOLD		15. MOTHER'S MAIDEN NAME First MARTHA Middle GROCK Last GROCK		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT ROETH RINGGOLD Address CELELY MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 3959 Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Aortic insufficiency DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 1969 , to 1969 , that (I) (we) last saw the deceased alive on 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE E. C. H. Schmidt		DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 25 Jan 69			
22d. PHYSICIAN'S NAME (Type) E. C. H. Schmidt		22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE JAN 28, 1969		23c. NAME OF CEMETERY OR CREMATORY SANDTOWN		23d. LOCATION (City or Town) (County) (State) HILLSBORO CAR. MD.			
24. FUNERAL DIRECTOR Charles Moore Denton		ADDRESS		25a. REC'D BY REGISTRAR JAN 30 1969		25b. REGISTRAR'S SIGNATURE Charles Moore Denton			

10310

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01562										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										01555									
1. DECEASED-NAME (Type or print)										20. DATE OF DEATH										2b. HOUR									
ARTHUR W. RUMSEY										Month 1 Day 21 Year 69										2:15 P.M.									
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)			IF UNDER 1 YEAR			IF UNDER 24 HRS.														
MALE			WHITE			10-13-82			86 YRS.			MONTHS			DAYS			HOURS											
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH																				
N.Y.			U.S.A.						TALBOT																				
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)					12b. KIND OF BUSINESS OR INDUSTRY														
EASTON					HOUSE IN THE PINES																								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE					13b. COUNTY					13c. CITY OR TOWN					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET AND NUMBER									
MD					TALBOT					OXFORD					YES					MORRIS STREET									
14. FATHER'S NAME First Middle Lost					15. MOTHER'S MAIDEN NAME First Middle Lost																								
CHARLES B. RUMSEY					FLORENCE E. WEAVER																								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)					16b. SOCIAL SECURITY NO.					17. INFORMANT Address																			
No					108-05-1519					LELAND C. RUMSEY, OXFORD, MD																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
PART I. DEATH WAS CAUSED BY:																													
IMMEDIATE CAUSE (a) <u>Congestive heart failure</u>															2 weeks														
DUE TO, OR AS A CONSEQUENCE OF																													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																													
(b) <u>Arteriosclerotic heart disease</u>															many years														
DUE TO, OR AS A CONSEQUENCE OF																													
(c)																													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from 6-6, 1967, to 1-21, 1969, that (I) (we) last saw the deceased alive on 1-15, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE										DEGREE					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED									
																				1-22-69									
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS																			
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City or Town) (County) (State)														
REMOVAL					1/25/1969					WOODLAWN CEMETERY					ELMIRA, N.Y.														
24. FUNERAL DIRECTOR										ADDRESS										25a. REGISTRY REGISTRAR									
Marion E. Weaver - Fox Eastern Md																				JAN 23 1969									
																				25b. REGISTRAR'S SIGNATURE									

11555

GENERAL OF DEATH

11555

I have been thinking of you very much lately
and wondering how you are getting on.
I hope you are well and happy.
I have been very busy lately
but I will try to write to you more often.
I have been thinking of you very much lately
and wondering how you are getting on.
I hope you are well and happy.
I have been very busy lately
but I will try to write to you more often.



EX-10101

THE UNIVERSITY OF CHICAGO
LIBRARY
11555

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR 100
30M REV. 1/78

01563				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				01556				
Item#13a,c,&e, FilmGL09 2/1/69				CERTIFICATE OF DEATH								
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			Month	Day	Year	2b. HOUR
Katherine Ogden Savage						Jan.			28	1969		128 M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		
FEMALE		WHITE		8-29-78		90 YRS.		MONTHS		DAYS		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH						
Brooklyn, N.Y.		USA				TALBOT Md.						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
EASTON			HOUSE IN THE PINES			Housewife			Own Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Wash. D.C.			TALBOT		D.C.				2400 16th Street			
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last	
Alfred Ogden						Kate Trecartin						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address			
no						John G. Williams			Philadelphia, Pa.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolus</u> <u>450X</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs.</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Pneumonia</u>												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION			Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <u>16 Sept</u> , 19 <u>65</u> , to <u>28 Jan</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>25 Jan</u> 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>Thorston Harrison M.D.</u>						22c. DATE SIGNED <u>29 Jan 69</u>		22d. PHYSICIAN'S NAME (Type) <u>THORSTON HARRISON</u>				
22e. ADDRESS <u>EASTON MARYLAND</u>												
23a. BURIAL (CREMATION REMOVAL) (Specify)			23b. DATE <u>Jan. 29, 1969</u>			23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>			23d. LOCATION (City or Town) (County) (State) <u>Washington, D.C.</u>			
24. FUNERAL DIRECTOR <u>W. R. Lock</u>						25a. REC'D BY REGISTRAR <u>W. R. Lock</u>		25b. REGISTRAR'S SIGNATURE <u>W. R. Lock</u>		DATE <u>JAN 30 1969</u>		

1152

1152

UNITED STATES OF AMERICA



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV. 11-68

MEDICAL CERTIFICATION

1. DECEASED-NAME (Type or print) JOHN LESTER SMITH			2a. DATE OF DEATH Month 1 Day 2 Year 69			2b. HOUR 1030 P. M.			
3. SEX MALE		4. RACE COLORED		5. DATE OF BIRTH 7-23-06		6. AGE (In years last birthday) 62 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) MD		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH TALBOT Md.			
10. CITY OR TOWN OF DEATH EASTON		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) laborer		12b. KIND OF BUSINESS OR INDUSTRY farmer			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD		13b. COUNTY TALBOT		13c. CITY OR TOWN ROYAL OAK		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Box 91	
14. FATHER'S NAME First William Middle Smith Last Smith			15. MOTHER'S MAIDEN NAME First Rosa Middle Cates Last Cates						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no		16b. SOCIAL SECURITY NO. 265-26-3820		17. INFORMANT Address Cates					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Fail 486x DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardia DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days 2 days									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 7 Jan , 19 69 , to 2 Jan , 19 69 , that (I) (we) last saw the deceased alive on 2 Jan , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE R. Lane Wroth, M.D.				DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type) R. Lane Wroth				M.D.		22e. ADDRESS St. Michaels, Maryland 21663			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 1/5/69		23c. NAME OF CEMETERY OR CREMATORY Deep neck		23d. LOCATION (City or Town) (County) (State) Royal Oak Md			
24. FUNERAL DIRECTOR Charles H. Deibel				ADDRESS Easton Md		25a. REC'D BY REGISTRAR 7		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01565

CERTIFICATE OF DEATH

01558

1. DECEASED-NAME (Type or print) First Middle Last KATHERINE M. SMITH			2a. DATE OF DEATH Jan. Month 13 Day 69 Year		2b. HOUR 130 A.M.
3. SEX FEMALE	4. RACE WHITE		5. DATE OF BIRTH 5-14-88		6. AGE (In years last birthday) 80 YRS.
7a. BIRTHPLACE (State or foreign country) Baltimore		7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH TALBOT Md.
10. CITY OR TOWN OF DEATH EASTON		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HOUSE IN THE PINES		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Saleslady	12b. KIND OF BUSINESS OR INDUSTRY Stewarts
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Talbot	13c. CITY OR TOWN Easton	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER Rd. 4, Box 308
14. FATHER'S NAME First Middle Last Mathias Leimkuhler			15. MOTHER'S MAIDEN NAME First Middle Last Amelia Koestner		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO. 213-30-6935		17. INFORMANT Address Charles A. Smith, son, above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pseudobulbar palsy 4409 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Uncertain					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 12-25 , 19 68 , to 1-13 , 19 69 , that (I) (we) last saw the deceased alive on 1-10 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Robert W. Trever DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED 1-13-68	
22d. PHYSICIAN'S NAME (Type) RD3 Easton, Md. 21601				22e. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 1/15/69		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem.	
23d. LOCATION (City or Town) (County) (State) Baltimore, Md.					
24. FUNERAL DIRECTOR 3331 Brehms Lane ADDRESS Schumann & Son (Per) P.M.L.				25a. REC'D BY REGISTRAR DATE JAN 16 1969	
				25b. REGISTRAR'S SIGNATURE Charles Judge	

1538

CERTIFICATE OF DEATH

1538

Name of Deceased		Date of Death	
Sex		Age	
Place of Birth		Usual Residence	
Cause of Death		Manner of Death	
Physician's Signature		Medical Examiner's Signature	
Date of Report		Place of Report	

BOX 501111

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1-64

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01566

CERTIFICATE OF DEATH

01559

1. DECEASED-NAME (Type or print) LOTTIE First Holden Middle SPARKS Last			2a. DATE OF DEATH Month 1 Day 21 Year 69			2b. HOUR 8:15 M	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 9-27-06		6. AGE (In years last birthday) 62 YRS.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH TALBOT Md.	
10. CITY OR TOWN OF DEATH EASTON		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY None	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) Maryland		13b. COUNTY QUEEN ANNES		13c. CITY OR TOWN CENTREVILLE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First John Middle Wesley Last Holden		15. MOTHER'S MAIDEN NAME First Mollie Middle L. Last BOOKER					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. 213-01-5672		17. INFORMANT Address Mrs. Sterling J. Walbert, Centreville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4123 Congestive heart failure DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) —							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Jan. 1967 Jan. 1964
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c) None							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from January, 1964 , to Jan. 21, 1969 , that (I) (we) last saw the deceased alive on 1-21 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Robert W. Trever				22c. DATE SIGNED 1-22-69			
22d. PHYSICIAN'S NAME (Type) Robert W. Trever				22e. ADDRESS M.D. Easton, Maryland 21601			
23a. BURIAL-CREMATORY, REMOVAL (Specify)		23b. DATE JANUARY 24, 1969		23c. NAME OF CEMETERY OR CREMATORY CHESTERFIELD CEMETERY		23d. LOCATION (City or Town) (County) (State) CENTREVILLE Q.A. Co Md.	
24. FUNERAL DIRECTOR John H. Baring Jr., Baiters Bus, Centreville, Md.		25a. REGD BY REGISTRAR JAN 27 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

HONORABLE

SIR:

DEAR SIR:

I have the honor

to

acknowledge the receipt of your letter of the 10th inst.

in relation to the proposed amendment to the charter of the

District of Columbia, and in reply to inform you that the same

has been forwarded to the proper authorities for their consideration.

Very respectfully,
Your obedient servant,

J. M. [Signature]

[Signature]

[Signature]

[Signature]

[Signature]

[Signature]

[Signature]

[Signature]

[Signature]

[Signature]

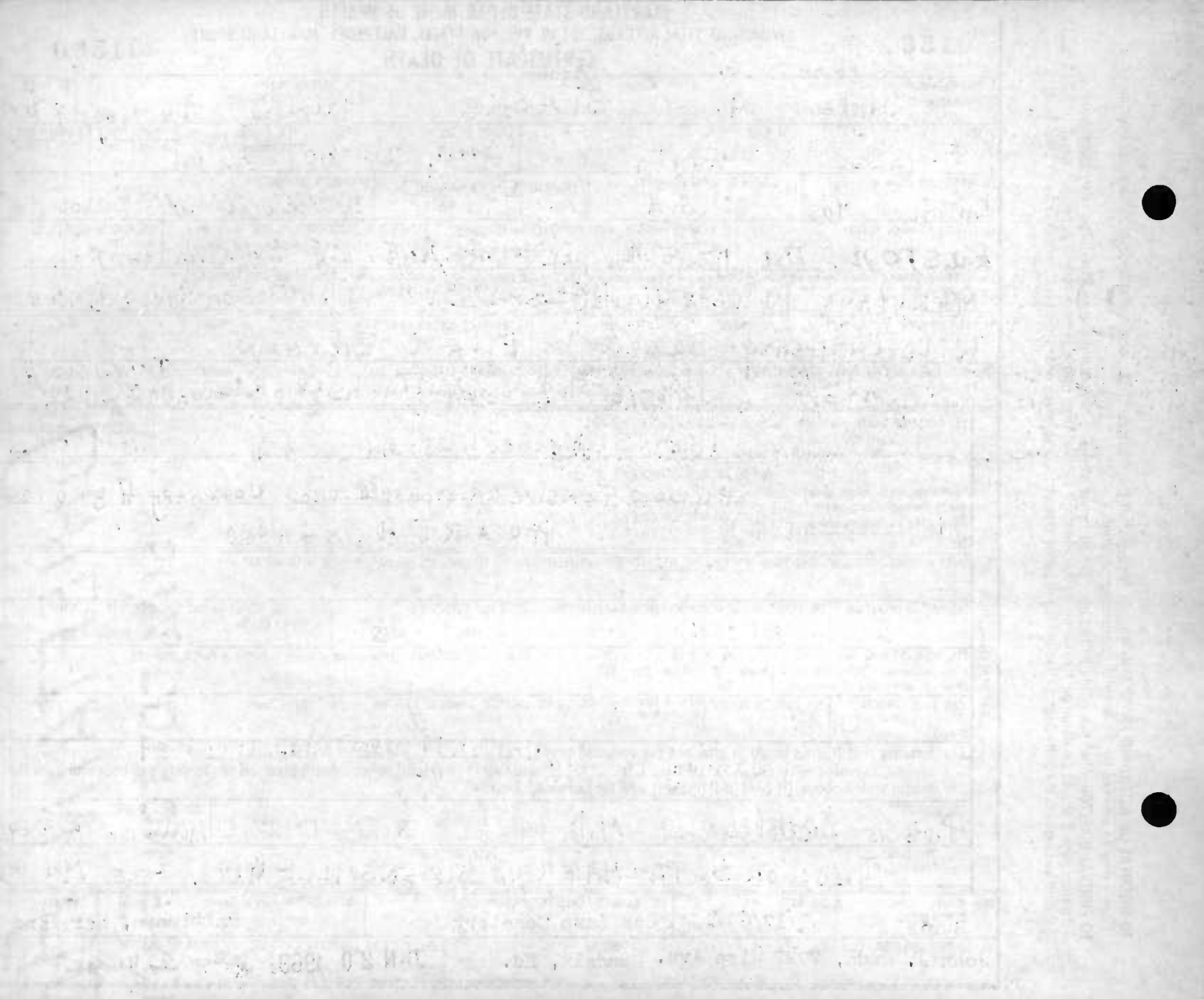
[Signature]

[Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 7 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01567		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				01560	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print) <u>Helen G. Stacks</u>				2a. DATE OF DEATH <u>January 14 1969</u>		2b. HOUR <u>9 P M</u>	
3. SEX <u>FEMALE</u>		4. RACE <u>White</u>		5. DATE OF BIRTH <u>July 24 1910</u>		6. AGE (In years last birthday) <u>58</u> YRS.	
7a. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Queen Anne's Talbot Md.</u>	
10. CITY OR TOWN OF DEATH <u>Easton's Md.</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A. Memorial Hospital Easton's Md.</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>housewife</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>MARYLAND</u> COUNTY <u>Queen Anne's</u>				13c. CITY OR TOWN <u>Grasonville</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <u>64 Chester River Drive</u>				14. FATHER'S NAME First <u>William Henry</u> Middle <u>Baker</u> Last <u>ELLA C. BIERMAN</u>			
15. MOTHER'S MAIDEN NAME First <u>ELLA C.</u> Middle <u>BIERMAN</u> Last <u>DUNDALK Md.</u>				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <u>no</u> (If yes give war or dates of service)			
16b. SOCIAL SECURITY NO. <u>216-16-5107</u>				17. INFORMANT <u>Joseph Stacks 6818 Holabird Ave 21222</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) <u>410.0 CORONARY OCCLUSION</u>						<u>1-1 1/2 HOURS</u>	
DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hyper Tensive arteriosclerotic</u>						<u>4 years</u>	
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Heart disease</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>MARCH 19 1965</u> to <u>January 14 1969</u> , that (I) (we) last saw the deceased alive on <u>January 14 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Theodor Sattelmaier M.D.</u> DEGREE <u>MD</u> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED <u>January 15 1969</u>			
22d. PHYSICIAN'S NAME (Type) <u>THEODOR SATTELMAIER MD</u>				22e. ADDRESS <u>STEVENSVILLE Queen Anne's Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>1/17/69</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR <u>John J. Duda, 7922 Wise Ave. Dundalk, Md.</u>				25a. REC'D BY REGISTRAR <u>JAN 20 1969</u> DATE		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please leave carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

4

1

01568

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01561

1. DECEASED-NAME (Type or print) <i>Charles Guy Steele</i>			2a. DATE OF DEATH Month <i>Jan</i> Day <i>17</i> Year <i>69</i>			2b. HOUR <i>4:30</i> M <i>M</i>					
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>Aug. 25, 1897</i>		6. AGE (In years last birthday) <i>71</i> YRS.		IF UNDER 1 YEAR MONTHS <i>0</i> DAYS <i>0</i>		IF UNDER 24 HRS. HOURS <i>0</i> MIN. <i>0</i>	
7a. BIRTHPLACE (State or foreign country) <i>Penna.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Talbot</i> Md.					
10. CITY OR TOWN OF DEATH <i>Easton</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Memorial</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Night watchman</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>None</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <i>Maryland</i> STATE				13b. CITY OR TOWN <i>Caroline Goldsboro</i>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>None</i>			
14. FATHER'S NAME First <i>Wilson</i> Middle <i>Steele</i> Last <i>Steele</i>				15. MOTHER'S MAIDEN NAME First <i>Mary</i> Middle <i>Houser</i> Last <i>Houser</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? <i>No</i> (If yes give year or dates of service)				16b. SOCIAL SECURITY NO. <i>220-01-5232</i>		17. INFORMANT <i>Eva Steele Goldsboro, Caroline, Md</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral thrombosis</i> <i>4330</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cerebral arteriosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Unknown</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>< 1 day</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Hypertensive cardiovascular disease</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <i>1-17</i> , 19 <i>69</i> , to <i>1-17</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>1-17</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. <i>I also attended deceased 10-67.</i>											
22b. SIGNATURE <i>Robert W. Trever, M.D.</i> DEGREE 22d. PHYSICIAN'S NAME (Type) <i>Robert W. Trever M. D.</i>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>1-17-69</i>			
23a. BURIAL, CREMATION, REINTERMENT <i>Burial</i>		23b. DATE <i>1-21-69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Greensboro</i>		23d. LOCATION (City or Town) (County) (State) <i>Greensboro, Caroline Md.</i>					
24. FUNERAL DIRECTOR <i>John E. Boulton</i> ADDRESS <i>Greensboro</i>						25a. REC'D BY REGISTRAR <i>Jan 21 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles J. J...</i>			

5042

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01569

01562

1. DECEASED-NAME (Type or print) Genie			First	Middle	Last	2a. DATE OF DEATH Month Jan Day 23 Year 1969			2b. HOUR 8p M		
3. SEX Male		4. RACE Negro		5. DATE OF BIRTH 6-4-92		6. AGE (In years last birthday) 76 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) N. CAROLINA		7b. CITIZEN OF WHAT COUNTRY? AMERICA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH TALBOT Md.					
10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Memorial Hosp		12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired) FACTORY WORKER		12b. KIND OF BUSINESS OR INDUSTRY NONE					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) MARYLAND		13b. COUNTY CAROLINE		13c. CITY OR TOWN RIDGELY		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER GENERAL DELIVERY			
14. FATHER'S NAME GUS		First		Middle		Last		15. MOTHER'S MAIDEN NAME MANDY		First Middle Last HARRIS	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, NO (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 228-206439		17. INFORMANT CLARA WILKINS (WIDOW)		Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myelophthasic anemia 1419 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Anaplastic squamous cell carcinoma DUE TO, OR AS A CONSEQUENCE OF (c) of the tongue metastatic to marrow APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1966											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from July , 19 66 , to 1-23 , 19 69 , that (I) (we) last saw the deceased alive on 1-23 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Robert W. Trever		M.D. DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1-23-69					
22d. PHYSICIAN'S NAME (Type) Robert W. Trever		22e. ADDRESS Easton, Maryland									
23a. BURIAL, CREMATION, REMOVAL, ETC. BURIAL		23b. DATE 1/28/69		23c. NAME OF CEMETERY OR CREMATORY SANDTOWN		23d. LOCATION (City or Town) (County) (State) HILLSBORO CAROLINE MD					
24. FUNERAL DIRECTOR Charles W Hill		ADDRESS Denton		25a. REC'D BY REGISTRAR JAN 27 1969		25b. REGISTRAR'S SIGNATURE					

[The main body of the page contains extremely faint, illegible text, likely bleed-through from the reverse side of the document. The text is arranged in several paragraphs and appears to be a formal letter or report.]

[The right margin contains faint, illegible text, possibly a continuation of the main text or a separate note. There are two large black circular marks on this side, one near the top and one near the bottom.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
01570					01563						
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) ^{First} Mary ^{Middle} Annie ^{Last} Wright					2a. DATE OF DEATH 1 Month 5 Day 1969					2b. HOUR M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH 8/1/1895			6. AGE (In years last birthday) 73 YRS.		7. UNDER 1 YEAR MONTHS DAYS		
7a. BIRTHPLACE (State or foreign country) Md		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Talbot Md.					
10. CITY OR TOWN OF DEATH Easton			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street and city) Memorial			12a. USUAL OCCUPATION (Kind of work done during part of working life, even if retired.) Housework			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY Talbot		13c. CITY OR TOWN Easton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Calvert Terrace		
14. FATHER'S NAME ^{First} William B. ^{Middle} Legg ^{Last}					15. MOTHER'S MAIDEN NAME ^{First} Elizabeth A. ^{Middle} Myers ^{Last}						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 216-56-16237		17. INFORMANT Address Edward M. Wright, Easton, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 2509 Acute Myocardial Infarction										1 day	
DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial C.V.D.										years	
DUE TO, OR AS A CONSEQUENCE OF (c) Disruptive Myocardium										years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE R. Lane Wroth, M.D.					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1-6-69				
22d. PHYSICIAN'S NAME (Type) R. Lane Wroth, M.D.					22e. ADDRESS Easton, Md.						
23a. BURIAL, CREMATION, or other disposition		23b. DATE 1/8/1969		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Memorial Park			23d. LOCATION (City or Town) Easton, Md.		(County) (State)		
24. FUNERAL DIRECTOR MURICE E. NEWMAN & SON, Easton, Md.					25a. REC'D BY REGISTRAR DATA 9 1969		25b. REGISTRAR'S SIGNATURE J. Charles Judge				

RECEIVED OF

11583

CERTIFICATE OF DEATH

11583

6

Name of Deceased		Date of Birth		Sex		Race		Religion		Marital Status		Occupation		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar		Signature of Witness	
John Doe		1900-01-01		Male		White		Catholic		Married		Farmer		Heart Disease		Home		1950-01-01		10:00 AM		J. Smith		A. Jones		B. Brown	